

EPSDT SCREENING SERVICES AND EPSDT SPECIAL SERVICES

POLICIES AND PROCEDURES



907 KAR 1:034
EPSDT SCREENING SERVICES AND
EPSDT SPECIAL SERVICES

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

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CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

EPSDT SCREENING SERVICES AND
EPSDT SPECIAL SERVICES MANUAL

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SECTION I- INTRODUCTION

I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program EPSDT Screening Services and EPSDT Special Services Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

This manual shall provide basic information concerning coverage and policy. It shall assist providers in understanding what procedures are reimbursable.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the EPSDT Program shall be specified in the body of this manual in Section IV.

SECTION II - KENTUCKY MEDICAID PROGRAM

II. KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the **payor** of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable payment.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

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If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Departments fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be **entitled** to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

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Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and **non-**covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
275 EAST MAIN STREET
FRANKFORT KY 40621

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If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d)(5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months shall elapse between EACH RECEIPT of the aged claim by the program.

D. Kentucky Patient Access and Care System (**KenPAC**)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

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E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-in.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager and pharmacy shall appear on the face of the card.

F. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a **capitation** managed care system for physical health services. The program places emphasis on access and continuity of care, quality assurance and improvement in health outcomes for participating Medicaid recipients. The Kentucky Health Care Partnership Program shall be implemented incrementally statewide beginning in 1997. Partnerships should be operational by January 1, 1999, or the state will begin a competitive bid process. Medicaid recipients residing in partnership regions and who are not recipients of Medicaid long term care services shall be eligible to receive

SECTION II - KENTUCKY MEDICAID PROGRAM

Medicaid services through regional partnerships. If a health care provider chooses to provide Medicaid services through the Kentucky Care Partnership Program the provider shall enroll in a regional partnership as a Medicaid network provider. The provider shall agree to provide, or arrange for the provision of, all Medicaid covered services in accordance with the terms and conditions specified by the Department. The provider shall also agree to the terms, conditions, and administrative procedures specified by the partnership related to the delivery of services. Healthcare providers may contact the Department for Medicaid Services for additional information relating to Medicaid services under the Kentucky Health Care Partnership Program.

G. Kentucky ACCESS

In accordance with 907 KAR 1:710, the Department shall implement, within the Medicaid Program, a **capitation** managed behavioral health care system called Kentucky ACCESS. Kentucky ACCESS shall be implemented on a regional basis, much like the physical health partnership regions. Services covered under Kentucky ACCESS will generally include those services provided by psychiatrists, community mental health centers, psychiatric hospital units and psychiatric residential treatment facilities (PRTF). It also includes substance abuse services for children under age 21 and medical detoxification services for all ages.

SECTION II - KENTUCKY MEDICAID PROGRAM

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR ~~3:065~~, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky initiative, a **capitation** non-emergency medical transportation delivery system excluding ambulatory stretcher services. The Department has entered into a contract with three other cabinets to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. EPSDT Screening Clinic and Staff

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is designed to make preventive health care available and accessible to Medicaid-eligible children. It does so by identifying physical or mental problems through periodic examinations of children and providing coverage of diagnostic services and health care needed to treat illness or conditions. EPSDT means a service provided to a child under age 21 to identify a potentially disabling condition and to provide or refer for diagnosis and treatment for the identified condition. Screening providers shall refer children for medical services outside the expertise of their profession for appropriate diagnosis and treatment as indicated.

Early and Periodic Screening, **Diagnosis** and Treatment (EPSDT) services shall be provided by any provider who meets the criteria listed below.

1. The clinic shall have a governing body, legally responsible for the conduct of the clinic, which designates a director or supervisor and establishes administrative and clinical policies.
2. Any EPSDT clinic or other organization qualified to provide screening services, including local health departments, shall be under the direction of a duly-licensed physician (M.D.), pediatric advanced registered nurse practitioner (ARNP), or registered professional nurse (R.N.) currently licensed by the State of Kentucky who shall be responsible for assuring that the requirements of participation are met and that the procedures established by the Medicaid Program are carried out.

SECTION III - CONDITIONS OF PARTICIPATION

3. Screening clinics conducted under the direction of a registered professional nurse shall have a physician licensed in Kentucky acting as medical consultant.
4. Screening examinations and tests performed by licensed professional staff or supportive staff under the direct supervision of the licensed professional shall be in accordance with the professional practice standards for the profession.
5. Personnel policies shall be developed to outline the requirements, functions, and responsibilities of each person on the "screening" team. Personnel policies establish the line of authority in the screening clinic and in the total organization thereby establishing requirements for maintaining the health of all personnel having direct contact with recipients. A copy of this shall be retained in the provider's files.
6. Administrative policies shall outline who is to conduct each test and include procedures for the initial contact, follow-up contacts, maintaining patient records, and transfer of information from one provider to another. A copy of this shall be retained in the provider's files.

B. EPSDT Special Services Clinic and Staff

An EPSDT Special Services provider shall meet the requirements for participation in the Kentucky Medicaid Program as specified in Chapter 907 of the Kentucky Administrative Regulations for the particular diagnosis and treatment services provided.

Except as otherwise specified in Chapter 907 of the Kentucky Administrative Regulations, a provider seeking to provide EPSDT Special Services shall first submit a provider enrollment application to the Department for Medicaid Services. In order to enroll, the provider shall submit documentation which establishes that all of the following conditions are met:

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1. The provider is licensed or certified under state law to provide the services, or if the license or certification is not available under state law, is otherwise authorized under state law to provide these services and is not suspended or otherwise disqualified.
2. If the provider is located out of state, the provider shall meet comparable requirements in the state in which he does business.

C. Services

1. EPSDT Screening Services

In accordance with 42 USC 1396d(r), the EPSDT screening provider shall provide ~~the basic~~ screening services for eligible recipients as appropriate for age and health history.

Screening services are defined as follows:

- a. Health and developmental history
- b. Unclothed physical examination
- c. Developmental assessment
- d. Vision and hearing assessments
- e. Assessment of immunization status and updating immunization
- f. Assessment of nutritional status
- g. Laboratory procedures:
 - 1) Hemoglobin or hematocrit
 - 2) Urinalysis
 - 3) Tuberculin skin test, if indicated
 - 4) Lead
 - 5) Serology for syphilis, if indicated
 - 6) Culture for gonorrhea, if indicated

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- 7) Other laboratory tests as determined to be medically necessary and as appropriate for age, sex, and health history
- h. Dental screening
For children age two (2) years and over, a direct referral to a dentist shall be required.
- i. Anticipatory guidance and health education
All children screened shall receive health education as indicated by the child's age, health, and parental or guardian necessity.

See Section IV, Services Covered, of this manual for a more detailed description of required services.

2. EPSDT Special **Services***

EPSDT Special Services are other health care, diagnostic services, preventive services, rehabilitative services, treatment, and other measures described in 42 USC Section 1396 d(a) that are not otherwise covered under the Kentucky Medicaid Program and that are medically necessary and pre-authorized to correct or ameliorate defects and physical and mental illnesses and conditions of children.

See Section IV, Services Covered, of this manual for more information.

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D. Medical Records for Screening Services and Special Services

The EPSDT provider shall maintain a medical record for each child screened or treated with all entries kept current, dated and signed by professional providing the service or counter-signed by supervising professional. The record shall include the following:

1. Child's medical history
2. Physical development and mental assessment findings
3. Growth and development records
4. Record of immunizations and laboratory tests (including negative results)
5. Copy of referral form
6. Follow-up information on referrals and treatments

All children's medical records shall be completed promptly and shall be systematically filed and retained for five (5) years and for any additional time as shall be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection or copying by Cabinet personnel.

E. Release of Information

EPSDT providers receiving requests for release of EPSDT findings to Boards of Education, Head Start Programs, or other agencies shall be directed to:

- a. Establish an agreement with the appropriate agency to safeguard confidential information. A copy shall be retained in the provider's files.
- b. Obtain written authorization from the parent or legal guardian for the release of EPSDT findings to other agencies.

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- c. Prior to releasing EPSDT findings, individual screening records shall be marked "confidential information."

F. Screening Clinic Site and Equipment

1. The provider shall be located in a facility that is constructed, equipped and maintained to insure the safety of the children and provide a functional, sanitary environment.
2. The area utilized during the screening examination shall provide adequate privacy.
3. The provider shall have the necessary equipment, in proper working order, to provide the basic screening tests outlined in this manual.

G. Review and Audit

The provider shall make available for review and audit by authorized representatives of the Department for Medicaid Services, the Office of the Inspector General, Attorney General, and Health Care Finance Administration all medical, administrative, and financial records pertaining to services provided.

H. Suspected Child Abuse or Neglect

Kentucky Medicaid recognizes that cases of suspected child abuse and neglect may be uncovered during examinations or treatments. If suspected cases are discovered, an oral report shall be made immediately by telephone or otherwise to a representative of the local Department for Community-Based Services Office. Within forty-eight (48) hours, a report in writing shall be made to protect the child involved. To facilitate reporting of suspected child abuse and

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neglect cases, legislation effecting the reporting of child abuse (KRS 620.030) is printed on the reverse of the Child Abuse Reporting Form (DSS-115). These forms may be secured from the local Department for Social Services office. A copy of this form is included in the Appendix.

I. Termination of Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulations which address the terms and conditions for provider termination and procedures for appeals in accordance with 907 KAR 1:671 and 907 KAR 1:672.

SECTION IV - SERVICES COVERED

IV. SERVICES COVERED

A. Screening Services

1. The EPSDT Screening Program is a preventive health care program for Medicaid-eligible children from birth through the end of the birth month of the twenty-first year. Coverage shall be provided for prescribed screenings at specified time intervals according to age (periodicity schedule) to identify potential physical and mental health problems.
2. The periodicity schedule was developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care. A copy of the Periodicity Schedule may be found in the Appendix.

B. Routine Screening Tests and Procedures

The following routine tests and assessment procedures shall be used in evaluating the health status of the child.

1. Medical History

- a. On the initial visit a complete age-appropriate medical history shall be obtained from the parent or legal guardian by qualified personnel and retained in the child's medical record.

The history shall include information on sexual development, lead and tuberculosis exposure, nutritional intake, substance abuse, and social, emotional and mental health status as appropriate for the child's age.

SECTION IV - SERVICES COVERED

- b. An updated medical history shall be obtained at each interval medical visit.
- c. On all visits, a consent form shall be signed by the parent or legal guardian authorizing the provider to perform any screening tests or other assessment procedures. The Department for Community-Based Services shall in some instances be the legal guardian for an eligible Medicaid child, and therefore, shall have authority to give the required written consent for EPSDT services, i.e., foster care children.
- d. The screening provider's professional staff (R.N., A.R.N.P., or M.D.) is responsible for obtaining the medical history. If this responsibility has been delegated by the professional to a trained paraprofessional, the professional shall review the findings with the parent or legal guardian at the time of the screening examination.

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2. Unclothed Physical Examination
 - a. An unclothed physical examination shall be performed during each visit by professional staff (R.N., A.R.N.P. or M.D.). The following shall be checked according to medical standards: pulse, blood pressure, respiration, head, eyes, ears, nose, mouth, pharynx, neck, chest, heart, lungs, abdomen, spine, genitals, extremities, joints, muscle tone, skin and neurological condition.
 - b. Height and weight shall be taken at each visit and plotted on a growth chart.
 - c. Head circumference and length of child shall be measured and plotted at each visit during the first three years of life.
 - d. Measurements shall be recorded and plotted using a standard growth chart as appropriate for age and sex.

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3. Assessment of Nutritional Status
 - a. This shall be accomplished in the basic examination or intake through questions about dietary practices. Examples are: Does your child have any unusual eating habits? Does your child sleep with a bottle? Please describe what your child eats on a daily basis.
 - b. If the information provided suggests dietary inadequacy, obesity or other nutritional problems, a further assessment shall be indicated, including family, socio-economic or community factors and quality and quantity of individual-diets. This assessment may be performed by the screening provider or referred on for treatment, including dietary counseling and nutritional education.

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4. Developmental Assessment and Mental Health Screening
 - a. The screening provider shall perform a complete developmental assessment at each visit which shall include a range of activities to determine whether an individual's developmental process falls within a normal range of achievement according to age group and cultural background. The provider may use a standardized screening device which is **normed** and validated for the age-group tested or may assess and document the following elements. At a minimum, the **following** areas shall be assessed:
 1. gross motor development, focusing on strength, balance, locomotion;
 2. fine motor development, focusing on eye-hand coordination;
 3. communication skills or language development, focusing on expression, comprehension, and speech articulation;
 4. self-help and self-care skills;
 5. cognitive skills, focusing on problem solving or reasoning.

SECTION IV - SERVICES COVERED

- b. A brief age-appropriate mental health screening shall be conducted at each visit. The screener may use any approved standardized device **normed** and validated for the age-group tested. At a minimum, the screener shall assess each child in the following areas:
 - 1. school and learning;
 - 2. management of anger, sadness, or other emotions;
 - 3. responsiveness to family values and responsibilities;
 - 4. active pursuit of interests;
 - 5. making and maintaining friendships;
 - 6. communication of needs and feelings;
 - 7. avoidance of trouble in the community, e.g., stealing, bullying, threatening, firestarting, vandalism;
 - 6. functioning in family relationships;

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9. ability to perform age-appropriate cognitive tasks;

10. ability to show empathy for others.

- c. If a standardized tool is not used, the screener shall document in the child's chart the mechanism used for both the developmental assessment and mental health screen and the results, recording how the above component of each were assessed.

Examples of standardized screening tests are the 1) Denver Developmental Screening test (developmental only), 2) Ages and Stages (developmental and mental), and 3) Pediatric Symptom Checklist (mental only).

5. Vision Screening

- a. Visual acuity shall be performed using the appropriate objective or subjective screening at each visit according to the American Academy of Pediatrics Recommendations for Pediatric Health Care.
- b. Visual acuity tests for children over 3 years of age shall be recorded in the child's chart, as indicated.
- c. For children under 3 years of age, documentation describing how vision was assessed shall appear for each visit (i.e., follows object, red reflex present).

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- d. There are established age-specific preventative screening recommendations for children, infant through 18 years of age. Please see the screening outline in the Appendix for examples of screening recommendations.
- 6. Hearing or Audiometric Screening
 - a. A hearing screening or audiometric screening shall be performed at each visit. Screenings may be objective or subjective as required by the American Academy of Pediatrics Recommendations for Pediatric Health Care.
 - b. For children age 3 and older, the actual decibels ~~for each~~ frequency shall be recorded in the child's chart, as indicated.
 - c. For children under 3 years of age, documentation concerning how hearing was assessed shall appear for each visit (i.e., response to voice, bell, rattle).
- 7. Dental Screening
 - a. A routine dental inspection shall be carried out each time the child is screened, from birth through 20 years of age. The examination shall include questioning of the parent or legal guardian (in children under age 3) of the presence of thumb sucking, lip biting, caries, tongue thrusting, non-erupted teeth, extra teeth, extended use of pacifier, or bottle feeding practices.

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- b. At age two (2), all children in the EPSDT Program shall be referred to a dentist for a diagnostic dental exam and any necessary treatment.
- c. The recommended preventive dental periodicity schedule is found in the Appendix of this manual. Please see Appendix for further information.

Preventive dental and treatment services may be obtained at any time from any dentist participating in the Kentucky Medicaid Dental Program.

8. Urinalysis

A urinalysis (blood, sugar, Ketone bodies, and protein) shall be performed according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

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9. Tuberculin Skin Tests

- a. A tuberculin skin test shall be performed according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
- b. A tuberculin skin test is valid for a period of one year.

10. Hematocrit or Hemoglobin

A hematocrit or hemoglobin shall be performed according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

11. Lead Poisoning

Risk assessments for lead poisoning shall be required at each screening from age six months up to age six (6) and documented in the child's record. Blood lead level tests shall be required at twelve (12) months and twenty-four (24) months.

Blood lead level tests shall also be required when there is a positive answer to any question on the risk assessments.

An initial home visit by a nurse is required for all children with confirmed blood lead levels of 20 ug/dl or above.

Please see Appendix for the requirements of a lead risk assessment and any necessary treatment.

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12. Immunization Assessment or Provision

An assessment of immunizations shall be performed during each visit. Immunizations shall be provided as necessary, according to the American Academy of Pediatrics (Committee on Practice and Ambulatory Medicine), Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

Please see the Immunization Chart in the Appendix.

13. Blood Pressure

A blood pressure shall be taken on children 35 months of age ~~and older~~ during each visit.

14. Pelvic Examination

A pelvic examination and pap smear shall be done or referred for sexually active children when indicated by the medical history and routinely for females 18 years of age and older. Consent shall be given by the child, parent, or legal guardian for every examination.

15. Other Tests

Other tests shall be done or referred when indicated, based on the child's health history, assessment, age, sex, clinical symptoms, and exposure to disease. Diagnostic testing may be provided or referred. Examples of other tests are urine screening, **pinworm** slide, urine culture, serological test, drug dependency screening, stool specimen for parasites, ova, blood, and HIV screening.

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16. Sick Cell

Routine testing for sickle cell anemia shall not be required. However, children determined to be at risk by review of their family history shall either be tested and treated by the screening provider or be referred to appropriate professional for testing and follow-up.

17. Health Education and Anticipatory Guidance

Health education and anticipatory guidance shall be done during each visit. Health education and counseling shall be provided to the parent or legal guardian and the child to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

C. Interperiodic Screenings

Interperiodic screenings which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions shall be covered under the EPSDT Program when not covered by other Medicaid Program elements including, but not limited to, vision, hearing, or dental. For additional information, contact the Children's Special Services Branch (See Appendix for telephone numbers).

D. Referrals

1. The Medicaid Program requests the assistance of the EPSDT provider in the identification and referral of clients who may be eligible for Women, Infants and Children (WIC) Supplemental Food Program. The WIC Program is designed to provide specific nutritional foods to pregnant women; breast-feeding

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women, up to one **(1)** year postpartum; or women to six **(6)** months postpartum, plus infants and children under five (5) years of age, who are income eligible and are determined to be at nutritional risk by a health professional.

The WIC Supplemental Food Program nutritional risk criteria and a list of local WIC Projects may be obtained from the Division of Adult and Child Health, Department for Public Health, located at 275 East Main Street, Health Services Building, Frankfort, Kentucky 40621; or by contacting the local county health department.

2. At the end of the screening examination, **abnormalities** noted shall be discussed in terms understandable and **meaningful** to the child, parent or guardian and either treated or referred by the screener for further assessment, diagnosis, and treatment to the appropriate health care professional.

Referrals made for diagnosis and treatment, and requests for transportation shall be performed as follows, except for managed care regions.

The legal guardian of a child in a managed care region should contact the managed care organization or the Empower Human Service Transport Regional Broker for specific instructions.

- a. Clients preferring to make **their own appointments** for diagnosis and treatment.
 1. Note the screening finding on a referral form and give two (2) copies of the completed referral form to the client for presentation to the referral resources.

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- b. Clients who request assistance with making appointments for diagnosis and treatment.
 - 1. The client shall have freedom of choice of referral providers. Appointments shall be made for diagnosis and treatment by the screening provider, if requested. If the client **chooses** a non-participating Medicaid provider, the client shall be responsible for payment of services.
 - 2. Note the screening finding on a referral form and forward two (2) copies of the completed referral form to the referral resource.
- c. Clients who request assistance with transportation shall be referred to the local Department for Social Insurance office, local managed care organization, or local Human Service Transportation Delivery Broker.
- 3. Other services needed by the child which are not referenced here may be reimbursed under the EPSDT Special Services Program. This program allows coverage for medically necessary services and treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. The service or treatment, however, shall be listed in Section 1905(a) of the federal Social Security Act which defines what services may be covered by state Medicaid programs. See "F. EPSDT Special Services" of this section for a list of services.

SECTION IV - SERVICES COVERED

Needed mental health services may be covered under Medicaid's Impact Plus Program. Examples of these services and how to obtain them can be found in the Appendix.

E. Diagnosis and Treatment

If referral for additional service is indicated, further diagnosis and medical treatment services shall be covered if they are:

1. Otherwise covered by the Medicaid Program
2. Not otherwise covered by the Medicaid Program but meet the requirements for EPSDT Special Services.

F. EPSDT Special Services

EPSDT **Special** Services are other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 USC Section **1396d(a)**, that are not otherwise covered under the Kentucky Medicaid Program and that are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions.

1. These services are as follows:
 - a. inpatient hospital services
 - b. outpatient hospital services
 - c. rural health clinic services
 - d. federally qualified health center services
 - e. other laboratory and x-ray services
 - f. early and periodic screening, diagnosis and treatment services
 - g. family planning **services and supplies**

SECTION IV - SERVICES COVERED

- h. physician services
- i. medical and surgical services furnished by a dentist
- j. medical care by other licensed practitioners
- k. home health care services
- l. private duty nursing services
- m. clinic services
- n. dental services
- o. physical therapy and related services
- p.** prescribed drugs
- q.** dentures
- r. prosthetic devices
- s.** eyeglasses
- t.** other diagnostic, screening, preventive,

(Proventive services are services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to

- a) prevent disease, disability, and other health conditions or their progression;
- b) prolong life; and
- c) promote physical and mental health and efficiency (42 CFR 441.130).

and rehabilitative services

(Rehabilitative services are other medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of

SECTION IV - SERVICES COVERED

physical or mental disability and restoration of a child to his best possible functional level (42 CFR 441.130).

- u. services in an intermediate care facility for the mentally retarded
- v. inpatient psychiatric hospital services for individuals under age 21
- w. nurse midwife services
- x. hospice care
- y. case management services
- z. other medical and remedial care specified by the Secretary of Health and Human Services
- aa. respiratory care services
- bb. certified pediatric nurse practitioner or family nurse practitioner
- cc. personal care services
- dd. primary care case management

Questions regarding the above-referenced coverages should be directed to the Department for Medicaid Services, Children's Special Services Branch. See Appendix for telephone numbers.

2. Coverage Guidelines

Services covered under the EPSDT Special Services Program shall be those services not covered under other Medicaid programs. For example, most vision, hearing, and dental services are covered under other Medicaid programs. If a child needs a third pair of eyeglasses in one year, but Medicaid's Vision Program only covers an original pair and a replacement pair, then the third pair of eyeglasses may be billed to and reimbursed by the EPSDT Special Services, if medically necessary.

SECTION IV - SERVICES COVERED

Since each child's case and request is individual, questions regarding which program to bill should be directed to the Children's Special Services Branch. (See Appendix for telephone numbers.)

All services in the EPSDT Special Services Program require a prior authorization. The prior authorization shall be accompanied by the following information:

- a. The primary diagnosis and significant associated diagnoses.
- b. Prognosis.
- c. Date of onset of the illness or condition, and etiology, if known.
- d. Clinical significance or functional impairment caused by the illness or condition.
- e. Specific types of services to be rendered by each discipline with physician's prescription where applicable.
- f. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals, if applicable.
- g. The extent to which health care services have been previously provided to address the defect, illness, or condition, and results demonstrated by prior care where applicable.
- h. Any other documentation necessary to justify the medical necessity of the requested service.

SECTION IV - SERVICES COVERED

2. Requests for approval of services shall meet the standard of medical necessity for EPSDT if the following criteria, where applicable, are met:
 - a. The services shall be to correct or ameliorate defects and physical and mental illnesses and conditions.
 - b. The services to be provided shall be medical or remedial in nature.
 - c. The services shall be individualized and consistent with the child's medical needs.
 - d. The services shall not be requested primarily for the convenience of the child, family, physician ~~or another~~ provider of services.
 - e. The services shall not be unsafe or experimental.
 - f. If alternative medically accepted modes of treatment exist, the services shall be the most cost-effective and appropriate service for the child.
 - g. The requests for diagnostic and treatment services **in community-based** settings may not be approved if the costs would exceed those of equivalent services at the institutional level of care. Each case shall be **individually assessed for appropriateness** in keeping with the standards of medical necessity and the best interest of the child.

SECTION IV - SERVICES COVERED

- h. The services to be provided shall be:
 - 1. generally recognized by the appropriate medical profession as an accepted modality of medical practice or treatment,
 - 2. within the authorized scope of practice of the provider, and
 - 3. an appropriate mode of treatment for the medical condition of the child.
 - i. Scientific evidence, if available, shall be submitted consisting of well-designed and well-conducted investigations published in peer-review journals, demonstrating that the service can produce measurable physiological outcomes, or, in the case of psychological or psychiatric services, measurable psychological outcomes, concerning the short and long term effects of the proposed service on health outcomes.
 - j. The predicted beneficial outcome of the services outweighs potential harmful effects.
 - k. The services improve the overall health outcomes as much as, or more than, established alternatives.
3. If the reimbursement is being sought on a by-report basis, a description of the service, the proposed unit of service, and the requested dollar amount shall be included with the request for authorization.

SECTION IV - SERVICES COVERED

4. Prior authorization requests for EPSDT Special Services shall be reviewed for medical necessity without regard to the source of the referral to the service.
5. All requests, except dental, for EPSDT Special Services shall be called in to the Department's Peer Review Organization (PRO) for prior approval. The PRO, before approval, may require additional written documentation from the provider. Please see Appendix for telephone numbers.

• •

SECTION V - REIMBURSEMENT

V. Reimbursement

The Department for Medicaid Services shall reimburse participating EPSDT providers for screenings and special services provided to Medicaid-eligible children under the age of twenty-one (21). The methods of reimbursement are outlined below.

A. Screenings

Reimbursement shall be made for four types of screenings: complete screenings, partial screenings, completion of partial screenings, and interperiodic screenings.

1. Complete Screenings

- a. A complete screening shall be defined as a screening examination which includes all tests and procedures recommended in the **periodicity** schedule for the child's age.
- b. For all age levels except the fifth year (kindergarten examination) and twelfth year (sixth grade examination), reimbursement shall be at a maximum of seventy dollars (\$70).
- c. For fifth year and twelfth year screenings, reimbursement shall be at a maximum of ninety dollars (\$90).

SECTION V - REIMBURSEMENT

2. Partial Screenings

- a. A partial screening shall be defined as a screening examination which includes, at least, a health history and an unclothed physical.
- b. Reimbursement shall be at a maximum of thirty dollars (\$30).

3. Completion of Partial Screenings

- a. A completion of a partial screening shall be defined as the completion, within thirty (30) days of the partial screening, all tests and **procedures** appropriate for the child's age.
- b. Reimbursement shall be made at a maximum of forty dollars (\$40).

4. Interperiodic Screenings

- a. Interperiodic screenings shall be defined as screenings provided in addition to the normal periodicity schedule screenings, which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions when not otherwise covered by another Medicaid Program.

SECTION V • REIMBURSEMENT

- b. An interperiodic screen shall be reimbursed a maximum of thirty dollars (\$30).

B. EPSDT Special Services

- 1. EPSDT Special Services which are the same as or similar to services covered in another program element shall be reimbursed at the rate normally reimbursed through that program element.
- 2. Other EPSDT Special Services which do not have established reimbursement rates shall be individually determined or negotiated with the provider based on the actual cost of the service.

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Committee on Practice and Ambulatory Medicine (RE 9535)

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

A prenatal visit is recommended for parents who are at high risk for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance and pertinent medical history. Every infant should have a newborn evaluation after birth.

AGE ¹	INFANCY ²					EARLY CHILDHOOD ³					MIDDLE CHILDHOOD ³					ADOLESCENCE ³												
	NEWBORN ¹	2-4w ¹	1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY																												
Infectious																												
MEASUREMENTS																												
Height and Weight																												
Head Circumference																												
Blood Pressure																												
SENSORY SCREENING																												
Vision																												
Hearing ⁴																												
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT ⁵																												
PHYSICAL EXAMINATION ⁶																												
PROCEDURES - GENERAL ⁶																												
Heterozygous/Metabolic Screening ⁶																												
Immunization ⁷																												
Lead Screening ⁸																												
Hematocrit or Hemoglobin																												
Urinalysis																												
PROCEDURES - PATIENTS AT RISK ¹⁰																												
Tuberculin Test ¹¹																												
Cholesterol Screening ¹²																												
STD Screening ¹³																												
Pelvic Exam ¹⁴																												
ANTICIPATORY GUIDANCE ¹⁵																												
Injury Prevention ¹⁶																												
Initial Dental Referral ¹⁷																												

Items, and are growing and developing in satisfactory fashion; no abnormal
findings may become necessary if circumstances suggest variations from normal.
avoid fragmentation of care.

18. Cholesterol screening for high risk patients per AAP - Statement on Cholesterol¹⁸ (1992)

1. Be available, encouraged, and instruction and support offered.
2. For newborns discharged in less than 48 hours after delivery.
3. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
4. A child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
5. If the patient is uncooperative, reaction within six months.
6. Some experts recommend objective appraisal of hearing in the newborn period. The Joint Committee on Infant Hearing has identified patients at significant risk for hearing loss. All children meeting these criteria should be objectively screened. See the Joint Committee on Infant Hearing 1994 Position Statement.
7. For history and appropriate physical examination. If suspicious, by specific objective or supplemental testing.
8. To be performed for patients at risk.
9. To be performed for patients at risk.
10. Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, laboratory errors of newborn, etc.) is discussed with the physician.
11. The test recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
12. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
13. These may be modified, depending upon entry point into schedule and individual need.
14. Metabolic screening (eg, hypothyroidism, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
15. Schedule(s) per the Committee on Infectious Diseases, published periodically in Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
16. Blood lead screen per AAP statement "Lead Poisoning: From Screening to Primary Prevention" (1993).
17. All menstruating adolescents should be screened.
18. Conduct objective urinalysis for leukocytes for male and female adolescents.
19. TB testing per AAP statement "Screening for Tuberculosis in Infants and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.
20. The range during which a vaccine may be provided, with the date indicating the preferred age.
21. Earlier initial dental evaluations may be appropriate for some children. Subsequent examinations as prescribed by dentist.
22. Cholesterol screening for high risk patients per AAP "Statement on Cholesterol" (1992). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
23. All sexually active patients should be screened for sexually transmitted diseases (STD).
24. All sexually active females should have a pelvic examination. A pelvic examination for routine pap smears should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
25. Appropriate discussion and counseling should be an integral part of each visit for care from birth to age 12, refer to AAP's injury prevention program (1994) as described in "A Guide to Safety Counseling in Office Practice" (1994).
26. From birth to age 12, refer to AAP's injury prevention program (1994) as described in "A Guide to Safety Counseling in Office Practice" (1994).
27. Earlier initial dental evaluations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

EPSDT FEDERAL AND STATE STANDARDSHealth History:

Complete History

Interval **History****initial Visit**

Each Visit

By History/Physical Exam:**Developmental** Assessment

(Age appropriate physical and mental health milestones)

Nutritional Assessment

Lead Exposure Assessment

Each Visit

Each Visit

Each visit from 6 mo. **thru** 6 yr. age**Physical Exam:**

Complete/Unclothed

Growth Chart

Vision Screen

Hearing Screen

Blood Pressure

Each Visit

Each Visit

Assessed each visit

According to recommended medical standards (AAP)

Assessed each visit

According to recommended medical standards (AAP)

According to recommended medical standards (AAP)

Laboratory:**Hgb/Hct**

Urinalysis

Lead Blood Level (Low Risk Hx)

Lead Blood Level (High Risk Hx)

Cholesterol Screening

Sickle Cell Screening

Hereditary/Metabolic Screening
(Newborn Screening)

STD Screening

Pelvic Exam (Pap Smear)

Tuberculin Test

According to recommended medical standards (AAP)

According to recommended medical standards (AAP)

12 mo. and 2 year age visit

Immediately

***According** to recommended medical standards (AAP)

Documentation X 1 for children determined to be at risk

According to Kentucky statute

According to recommended medical standards (AAP)

According to recommended medical standards (AAP)

According to recommended medical standards (AAP)

Immunizations:

DPT

DTaP**OPV**

Hepatitis B

HiB

MMR

Varicella

Td**PPD**

Accessed each visit

According to recommended medical standards (AAP)

(ACIP)

W F P)

Health Education/Anticipatory Guidance

(Age Appropriate)

Each visit

Dental Referral

Age 2

AAP American Academy of Pediatrics
(Committee on Practice and Ambulatory Medicine)
ACIP Advisory Committee on Immunization Practices
AAPF American Academy of Family Physicians

Periodicity Schedule

The ages for screening examinations listed below are in accordance with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.

Infancy

0-1 month
2 months
4 months
6 months
9 months
12 months

Middle Childhood

5 years
6 years
8 years
10 years

Early Childhood

15 months
18 months
24 months
3 years
4 years

Adolescence

11 years
12 years
13 years
14 years
15 years
16 years
17 years
18 years
19 years
20 years

Age-Specific Preventive Screening Recommendations for Vision (Optometry)

I. Birth to 18 months

Screening/Remain Alert for

Recommended Screening Procedure(s)

Hereditary/congenital eye anomalies (HR)

Prenatal/family history
Observation
Ophthalmoscopy

Retinopathy of prematurity (HR)

Ophthalmoscopy

Ocular misalignment/strabismus

Prenatal/family history
Observation
Bruckner/Hirschberg/
Cover test

High refractive errors (HR)

Prenatal/family history
Ophthalmoscopy
Bruckner test

II. Ages 2-8

Screening/Remain Alert for

Screening Procedure(s)

Amblyopia

Monocular visual acuity

High refractive errors

Patient history
Bruckner test
Monocular visual acuity
Plus lens test

Ocular misalignment/strabismus

patient history
Observation
Bruckner/Hirschberg/
Cover test

Color vision

Ishihara plates or
equivalent

Eye Injury/environmental hazards

parent counseling

III. Ages 7-12 and 13-18

Screening/Remain Alert for

Screening Procedure(s)

Non-strabismic binocular vision dysfunctions

patient history

Eye injury/environmental hazards

patient/ parent counseling

(It is expected that by this age the child will have seen an **eyecare** professional for a full eye exam: if the child has not seen an **eyecare** professional appropriate screening tests from ages 2-6 screening should be administered.)

(HR)= high risk patients

VISION SCREENING GUIDELINES
(Ophthalmology)
(FOR AGES 3-5 AND AGES 6 AND OLDER)

Appendix IV
Page 3

FUNCTION AND RECOMMENDED TESTS	REFERRAL CRITERIA	COMMENTS
Distance Visual Acuity Snellen Letters Snellen Numbers Tumbling E HOTV Picture Tests Allen Fig. LH Test	Ages 3-5 1. Less than 4 of 6 correct on 20 foot line with either eye tested at 10 feet monocularly (ie, Less than 10/20 or 20/40). 2. Two-line difference between the two eyes even within the passing range (ie 10/12.5 and 10/20 or 20/25 and 20/40). Ages 6 and older: 1. Less than 4 of 6 correct on the 15 foot line with either eye tested at 10 feet monocularly (ie, Less than 10/15 or 20/30). 2. Two-line difference between the eyes, even within the passing range (ie, 10/10 and 10/15 or 20/20 and 20/30).	1. Tests listed in decreasing order of cognitive difficulty, the highest test that the child is capable of performing should be used, in general, the Tumbling E or the HOTV test should be used for ages 3-5 years and Snellen Letters or Numbers for ages 6 and older 2. Testing distance of 10 foot is recommended for all visual acuity tests. 3. A line of figures is preferred over single figures 4. Non-tested eye should be covered by Occluder held by examiner or by adhesive occluder applied to eye; the examiner must ensure that it is not possible to peek with the untested eye.
Ocular Alignment Unilateral cover test at 10 feet or 3 meters or Random Dot E stereotest at 40 cm (630 secs of arc)	Any eye movement Less than 4 of 6 correct	

Developed by:
 American Academy of Pediatrics, Section of Ophthalmology Executive Committee, 199 1-92
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 Walter Fierson, MD
 Jane D. Divlin, MD
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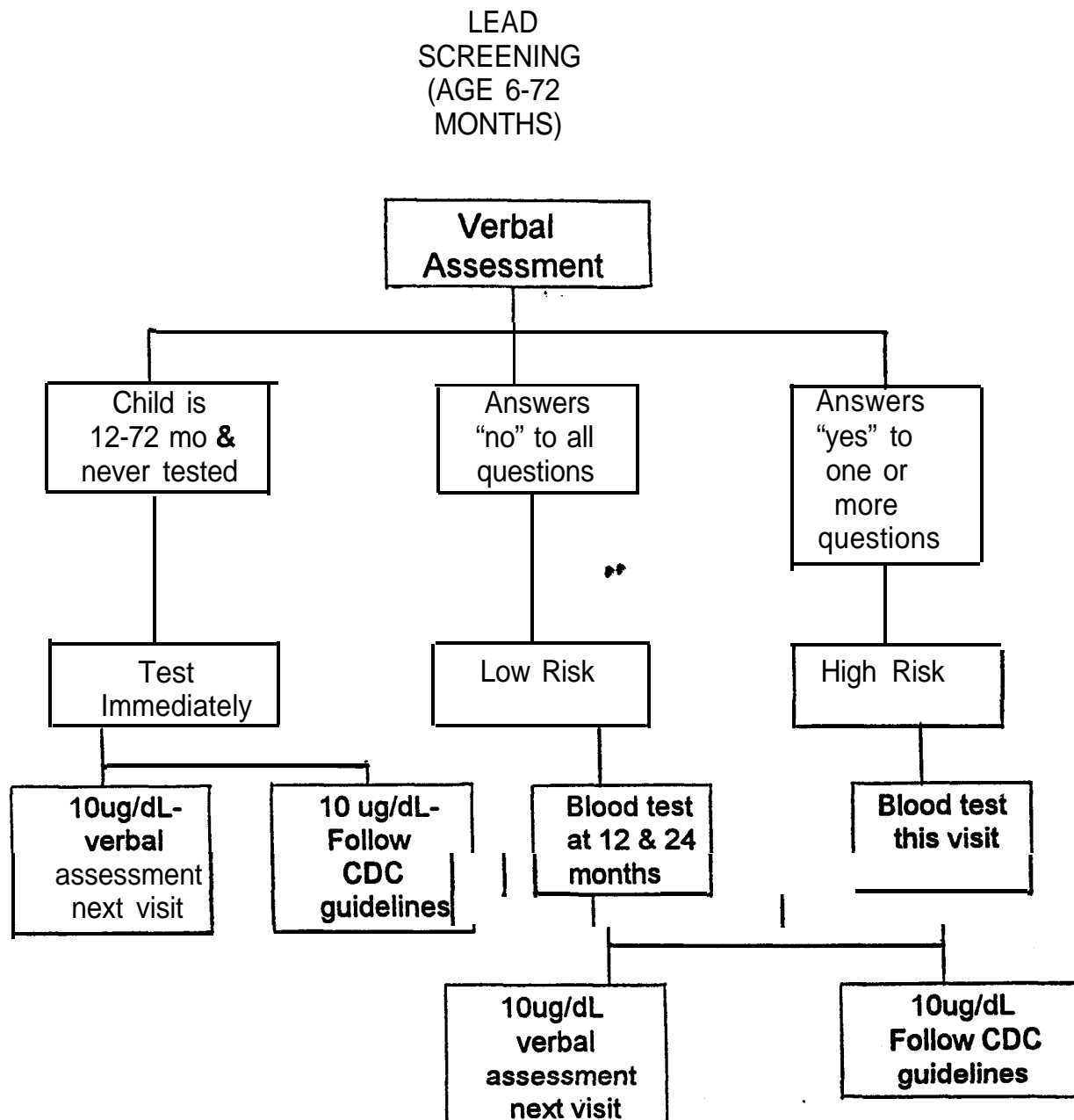
Risk Assessment Questions for Lead Poisoning

The following situations may create lead exposure for a child. Review of each of these risk assessment questions at each preventive health visit for children six months of age up to age 6. Document in each child's medical record at every visit that the assessment was done, any positive response(s) and action taken.

Does your child:

1. Live in or regularly visit a house with peeling or chipping paint built before **1960**? This could include a day care center, preschool, the home of a baby-sitter or a relative, etc.
2. Live in or regularly visit a house built before 1960 with recent, ongoing or planned renovations or remodeling?
3. Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning (that is, blood level at or above 20 ug/dL?
4. Live with an adult whose job or hobby involves exposure to lead, (Ex.) work with lead batteries, firing range, work with a chemical and chemical preparations, bridge, tunnel and elevated highway construction, etc.
5. Live near an active lead smelter, battery recycling plant or other industry likely to release lead?
6. Live near a heavily traveled major highway where soil and dust may be contaminated with lead?
7. Does your home's plumbing have lead pipes or copper with lead solder joints?
8. Do you give your child any home or folk remedies which may contain lead?
9. Has your child ever had a blood lead test?

LEAD SCREENING GUIDELINES



COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL SERVICES

CONFIDENTIAL
SUSPECTED ABUSE/NEGLECT, DEPENDENCY OR EXPLOITATION REPORTING FORM

TYPE REPORT: ☐ Child ☐ Adult ☐ Spouse County of Report _____

Time Report Received _____

Report Date _____

Incident Date(s) _____

1. Name(s)

Age

Sex

Sature of Report

a. _____
b. _____
c. _____
d. _____
e. _____

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1. Phvsical Injury
2. Sexual Abuse
3. Mental injury
4. Neglect
3. Dependency

6. 7. Adult Spouse Abuse Abuse

8. 9. Self-Neglect Caretaker Neglect
10. Exploitation

2. Current Address _____
Street/Rural Route City Zip County Telephone #

3. Directions _____

4. Parent(s) /Guardian/Caretaker _____ Relationship _____

5. Other Known Household Members _____

6. Describe nature/extent/causes of **abuse/neglect/dependency**, or exploitation. List witnesses and/or **collateral** contacts, previous incidents or reports. Describe **behavior** of adult victim and of alleged perpetrator (dangerous?)

7. Alleged Perpetrator, if different from 4 above

S a m e _____ Relationship _____

Address _____
Street/Rural Route City Zip County Telephone #

8. Person Taking Report _____ Title _____

9. Worker Assigned to Investigate _____ County _____ Telephone # _____

by: Family Services Office Supervisor _____

10. ATTENTION: LAW ENFORCEMENT ☐ **Certification** of Receipt of Report on Form JC-3 or by Other **Law** Enforcement Means.

Kentucky Revised Statutes. Chapter 620.030 an&or **209.030(2)**, dealing with suspected child **physical or sexual** abuse and suspected adult abuse, neglect, exploitation, or spouse abuse requires the Department for **Social** Services to notify the appropriate law enforcement agency.

INTERVENTION REQUESTED ☐ ☐ At your discretion

☐ Sent to: _____ . County Attorney

11. Person Making Report _____ Title/Relationship _____

Address _____
Street/Rural Route City Zip County Telephone #

PEDIATRIC SYMPTOM CHECKLIST

Appendix VII

Child's Name: _____

School Child Attends: _____

Today's Date: _____

Child's Birth Date: _____

Child's Sex: _____ Male Female

Age: _____

Grade in school: _____

Do you have any health, behavior or school concerns today?

☐ yes

☐ no

If yes, what are they? _____

Has he/she ever had any counseling?

☐ yes

☐ no

Are you a single parent?

☐ yes

☐ no

Form filled out by: _____ Mother _____ Father _____ B o t h Foster Parent Other

Please mark under the heading that best fits your child:

Never

Sometimes

Often

1. Complains of aches or pains

2. Spends more time alone

3. Tires easily, little energy

4. Fidgety, unable to sit still

5. Has trouble with a teacher

6. Less interested in school

7. Acts as if driven by a motor

8. Daydreams too much

9. Distracted easily

10. Is afraid of new situations

11. Feels sad, unhappy

12. Is irritable, angry

13. Feels hopeless

14. Has trouble concentrating

15. Less interest in friends

16. Fights with other children

17. Absent from school

18. School grades dropping

19. Is down on him or herself

20. Visits doctor with doctor finding nothing wrong

21. Has trouble with sleeping

22. Worries alot

23. Wants to be with you more than before

24. Feels he or she is bad

25. Takes unnecessary risks

26. Gets hurt frequently

27. Seems to be having less fun

28. Acts younger than children his or her age

29. Does not listen to rules

30. Does not show feelings

31. Does not understand other people's feelings

32. Teases others

33. Blames others for his or her troubles

34. Takes things that do not belong to him or her

35. Refuses to share

Recommendations for Preventive Pediatric Dental Care*

Because each child is unique these Recommendations are designed for the care of children who have no important health problems and are developing normally. These Recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The Academy emphasizes the importance of very early professional intervention and the continuity of care based on the individual needs of the child.

Age ¹	Infancy 6-12 Months	Late Infancy 12-24 Months	Preschool 2-6 Years	School-Aged 6-12 Years	Adolescence 12-21 Years
	Parents/Guardians/ Caregivers	Parents/Guardians/ Caregivers	Child/Parent/ Caregivers	Child/Parent/ Caregivers	Patient
Oral Hygiene Counseling ²	*	*	*	*	*
Injury Prevention Counseling ³	*	*	*	*	*
Dietary Counseling ⁴	*	*	*	*	*
Counseling for Non-nutritive Habits ⁵	*	*	*	*	*
Fluoride Supplementation ⁶	*	*	*	*	*
Assess Oral Growth & Development ⁷	*	*	*	*	*
Clinical Oral Exam	*	*	*	*	*
Prophylaxis and Topical Fluoride Treatment ⁸	*	*	*	*	*
Radiographic Assessment ⁹			*	*	*
Pit and Fissure Sealants			If indicated on primary molars	1st permanent molars as soon as possible after eruption	2nd permanent molars as soon as possible after eruption
Treatment of Dental Injury	*	*	*	*	*
Assessment and Treatment of Developing Malocclusion			*	*	*
Substance Abuse Counseling				*	*
Referral for regular and Periodic Dental Care					*
Anticipatory Guidance ¹⁰	*	*	*	*	*

1. First exam at the eruption of the 1st tooth and no later than 12-18 months.
2. Initially, responsibility of parent; as child develops jointly with parents; then when indicated only child
3. Initially play objects, pacifiers, car seats; then when learning to walk; and finally sports and routine playing.
4. At every appointment discuss the role of refined carbohydrates; frequency of snacking
5. At first discuss the need for additional suck & digits Vs pacifiers;

- then the need to wean from the habit before the eruption of the first permanent front teeth.
6. As per AAP/ADA Guidelines and the water source
7. By clinical examination.
8. Especially for children at high risk for caries and periodontal diseases.
9. As per AAPD Radiographic Guidelines.
10. Appropriate discussion and counseling, should be an integral part of each visit for care.

* American Academy of Pediatric Dentistry, May, 1992

Recommendations for Preventive Pediatric Dental Care*

Periodicity of Examination, Preventive Dental Services, and Oral
Treatment for Children
Revised May, 1992

Birth - 12 Months

1. Complete the clinical oral exam and appropriate diagnostic tests to assess oral growth and development and/or pathology
2. Provide oral hygiene counseling for parents, guardians and caregivers
3. Remove supra- and subgingival stains or deposits as indicated
4. Assess the child's systemic fluoride status and provide fluoride supplementation if indicated, following drinking water analysis
5. Assess appropriateness of feeding practices
6. Provide dietary counseling related to oral health
7. Provide injury prevention counseling for orofacial trauma (play objects, pacifiers, car seats, etc.)
8. Provide counseling for oral habits (digit, pacifiers, etc.)
9. **Provide diagnosis and required treatment** for any oral diseases or injuries
10. Provide anticipatory guidance for parent/guardian.

12 - 24 Months

1. Repeat 6-12 month procedures every six months or as indicated by individual patient's **needs/susceptibility to** disease
2. Assess topical fluoride status and give parental counseling
3. Provide injury prevention counseling for orofacial trauma (learning to walk, run, etc.)

2 - 6 Years

1. Repeat 12-24 month procedures every six months or as indicated by individual patient's needs/susceptibility to disease
2. Provide age-appropriate oral hygiene instructions
3. Complete a radiographic assessment of pathology **and/or** abnormal **growth and development, as indicated** for individual patient's needs
4. Scale and clean the teeth every six months or as indicated by the individual patient's needs
5. Provide topical fluoride treatments every six months or as indicated by the individual patients needs
6. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs
7. Provide counseling and services (athletic mouth guards) as needed for **orofacial trauma prevention**
8. **Provide assessment/treatment or referral of developing malocclusion as indicated by individual patients needs**
9. **Treat any oral diseases/habits/injuries as indicated.**

6 - 12 Years

1. Repeat 2-6 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease
2. Provide injury prevention counseling/services for orofacial trauma (sports activities)
3. Provide substance abuse counseling (smoking, smokeless tobacco, etc.)

12-21 Years

1. Repeat 6-72 year procedures every six months or as indicated by individual patient's needs/susceptibility to disease
2. At an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing dental treatment.

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE* United States, January -- December 1998

VACCINE	AGE										
	Birth	1 Mo.	2 Mos.	4 Mos.	6 Mos.	12 Mos.	15 Mos.	18 Mos.	4-6 Yrs.	11-12 Yrs.	14-16 Yrs.
Hepatitis B ¹⁸	Hep B-1									<u>Hep B³</u>	
		Hep B-2			Hep B-3						
Diphtheria and tetanus toxoids and pertussis ¹			DTaP or DTP	DTaP or DTP	DTaP or DTP		DTaP or DTP ¹		DTaP or DTP		Td
Haemophilus influenzae type b ^{**}			Hib	Hib	Hib		Hib				
Poliovirus ¹¹			Polio	Polio	Polio ¹¹				Polio		
Measles-mumps-rubella ⁶⁸						MMR			MMR	<u>MMR</u>	
Varicella virus ¹⁹						Var				<u>Var</u>	

Example	Range of Acceptable Ages for Vaccination
<u>Example</u>	Vaccines to Be Assessed and Administered if Necessary

* This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines; **vaccines** are listed under the ages for which they are routinely recommended. Catch-up immunization should be done during any visit when feasible. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

† Infants born to hepatitis B **surface antigen (HBsAg)-negative mothers** should receive 2.5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B®). The second dose should be administered at least 1 month after the first dose. The third dose should be administered at least 2 months after the second but not before 6 months of age. Infants born to **HBsAg-positive** mothers should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth, and either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) at a separate site. The second dose is recommended at age 1-2 months and the third dose at age 6 months. Infants born to mothers whose **HBsAg status is unknown** should receive either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) within 12 hours of birth. The second dose of vaccine is recommended at 1-2 months of age and the third dose at 6 months of age. Blood should be drawn at the time of delivery to determine the mother's HBsAg status; if it is positive the infant should receive HBIG as soon as possible (no later than age 1 week). The dosage and timing of subsequent vaccine doses should be based on the mother's HBsAg status.

§ Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any visit. Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series during the routine visit to a health-care provider at age 11-12 years, and unvaccinated older adolescents should be vaccinated whenever possible. The second dose should be administered at least 1 month after the first dose, and the third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose.

¶ Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received one or more doses of whole-cell diphtheria and tetanus toxoids and pertussis vaccine (DTP). Whole-cell DTP is an acceptable alternative to DTaP. The fourth dose (DTP or DTaP) may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and if the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids, absorbed, for adult use (Td), is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of DTP, DTaP, or diphtheria and tetanus toxoids, absorbed, for pediatric use (DT). Subsequent routine Td boosters are recommended every 10 years.

** Three *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If *Haemophilus* b conjugate vaccine (meningococcal protein conjugate) (PRP-OMP) (PedvaxHIB® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.

†† Two poliovirus vaccines are currently licensed and distributed in the United States: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable to the ACIP, AAP, and AAFP. Parents and providers may choose among these options: 1) two doses of IPV followed by two doses of OPV; 2) four doses of IPV; or 3) four doses of OPV. ACIP recommends two doses of IPV at ages 2 and 4 months followed by a dose of OPV at age 12-18 months and at 4-6 years. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

‡ The second dose of measles-mumps-rubella vaccine (MMR) is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 1 month has elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11-12 years.

¶¶ Susceptible children may receive varicella vaccine (Var) at any visit after the first birthday, and those who lack a reliable history of chickenpox should be vaccinated during the routine visit to a health-care provider at age 11-12 years. Susceptible children aged ≥ 13 years should receive two doses at least 1 month apart.

Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

Source: Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP)

UNISYS MEDICAID'S FISCAL AGENT INFORMATION

Unisys Corporation
Addresses:

Accident & Work Related
Post office Box 2107
Frankfort, KY 40602

Adjustments & Claim Credits
Post Office Box 2108
Frankfort, KY 40602
Claims Submission
Post Office Box 2101
Frankfort, KY 40602

Electronic Claims Submission
Post Office Box 2016
Frankfort, KY 40602

Provider Relations (Inquiries)
Post Office Box 2100

Frankfort, KY 40602

Third Party Liability
Post Office Box 2107
Frankfort, KY 40602

Unisys Telephone Numbers
In State-Kentucky:
Electronic Claims 8001205-4696
Inquiries: **800/807-1 232**
Unisys Automated Voice Response
System: 8001807-1 301 Available 24 Hours

REFERENCE LIST

Department for Medicaid Services
Addresses:

Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

Department for Medicaid Services
In State & Out-of-State

Eligibility (Recipient) **502/564-6885**

Fraud Hotline **800/372-2970**

Policy **502/564-6890**

Enrollment (Provider) **502/564-3476**

Third Party Liability **502/564-6205**

Where to Order

Diagnostic Code Books
International Classification of Diseases
American Medical Association
P.O. Box 7046; Attn: Order Dept.
Dover, DE 19903-7046

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Diagnostic and Statistical Manual
of Mental Disorders (DSM-IV)
American Psychiatric Association
1400 K Street NW
Washington, DC 20005

HCFA-1500 **(12/90)** Claim Forms
Superintendent of Documents
Post Office Box 371954
2021512-1 800

Health Care Review Corporation (PRO)
9200 Shelbyville Road, Suite 800
Louisville, Kentucky 40222
I-800-292-2392
Fax: (502) 429-5233

Impact Plus Services

Impact Plus Services are available to Medicaid-eligible children with complex mental health needs who are either in an institution currently or at risk of institutionalization and are approved by the local Regional Interagency Council (RIAC).

Examples of services covered under Impact Plus include individual and group services, collateral services, substance abuse services, therapeutic foster care, day treatment, partial hospitalization, crisis stabilization, and **Wilderness Camp**. Impact Plus services are provided by mental health professionals.

All Impact Plus **services** shall be prior-authorized by the local **RIAC**. If you, a child or parent need additional information about Impact Plus, please contact the Department for Medicaid Services, Children's Special **Services** Branch staff at (502) **564-6890**.

